Whom may we thank for referring you to this office...? _____

Application for Care at E.P. True Chiropractic

Date: _____ HRN: _____

Patient Demographics:

Name: _____ Birth Date: ____/____/____ Age: _____ ***Circle***: Male / Female

Address: _____ City: _____ State: _____ Zip Code: _____

E-Mail Address: _____ Home Phone_____ Mobile Phone_____

Marital Status: ***Circle***: Single / Married | Do you have insurance? ***Circle***: Yes / No | Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of Children and Ages: _____

Name & Number of Emergency Contact: _____

History of COMPLAINT:

Please identify the condition(s) that brought you to the office:

Then below on a scale of 1-10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling a number:

Primary: _____

Primary or chief complaint: 1- 2- 3- 4- 5 - 6 - 7 - 8 - 9 – 10

Secondarily: _____

Secondary Complaint: 1- 2- 3- 4- 5 - 6 - 7 - 8 - 9 – 10

Third: _____

Third Complaint: 1- 2- 3- 4- 5 - 6 - 7 - 8 - 9 – 10

When did the problem begin? _____ When is the problem the worst? ***Circle***: AM / PM / mid-day / late PM

How long does pain last? ***Circle***: Is it constant? / Experience it on and off throughout day / It comes and goes

How did the injury happen?

_____

Have these conditions ever been treated in the past? ***Circle***: Yes / No

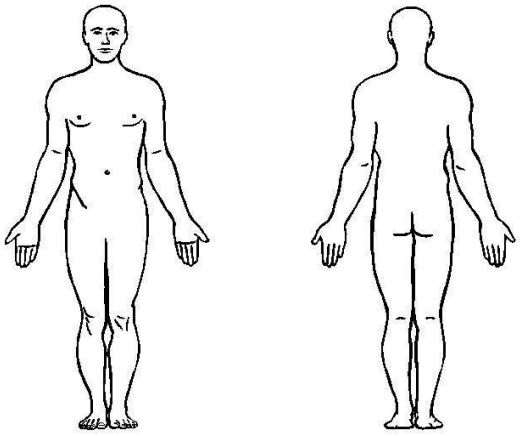
If yes, when: _____ and by whom? _____

How long were you under this care? _____ What were the results? _____

Name of Previous Chiropractor? _____ or ***Circle*** N/A

Please mark the areas on the diagram below with the following letters to describe your symptoms

R = Radiating (does it move), **B** = Burning **D** = Dull, **A** = Aching **N** = Numbness, **S** = Sharp/Stabbing, **T** = Tingling



What relieves your symptoms?

_____

_____

What makes them feel worse?

_____

_____

	List any Restricted Activity:	Current Activity Level:	Usual Activity Level:
1.	_____	_____	
2.	_____	_____	
3.	_____	_____	
4.	_____	_____	

Is your current issue a result of ANY type of accident? ***Circle***: Yes / No

Please identify any other injuries to your spine, minor or major, that the doctor should know about:

_____

_____

_____

Past History:

Have you ever suffered with any of this or a similar problem in the past? ***Circle***: Yes / No

If yes, how many times? _____ When was the last episode? _____

How did the injury happen? _____

Other forms of treatment tried? ***Circle***: Yes / No
If yes, please state what types of treatment: _____, and
who provided it: _____, How long ago? _____ What were the results? ***Circle***
Favorable / Unfavorable and please explain: _____

_____

Please identify and all types of jobs you have in the past that have imposed any physical stress on you or your body:

_____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for *Past*, **C** for *Currently have*, and **N** for *Never had*:

Broken Bone___	Dislocations____	Tumors____	Rheumatoid Arthritis____	Fracture____	Cancer____
Heart Attack___	Osteo Arthritis ___	Diabetes____	Cerebral Vascular_____	Disability____	

Other serious conditions: _____

Please Identify **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

	How Long Ago…	Type of Care Received…	By Whom…
Injuries			
Surgeries			
Childhood Diseases			
Adult Diseases			

Social History:

1. Smoking ***Circle*** (cigars / pipe / cigarettes) » How often? ***Circle*** Daily / Weekends / Occasionally / Never
2. Alcoholic Beverage: Consumption occurs » ***Circle*** Daily / Weekends / Occasionally / Never
3. Recreational Drug Use: » ***Circle*** Daily / Weekends / Occasionally / Never
4. Hobbies/Recreational Activities/Exercise Regime: How does your present problem affect the following, see pg. 2 where activities of daily life are located.

Family History:

1. Does anyone in your family suffer with the same condition(s)? ***Circle*** Yes / No
   If yes, whom? ***Circle*** (Grandmother / Grandfather / Mother / Father / Sister / Brother / Son(s) / Daughter(s)
   Have they ever been treated for their condition? ***Circle*** Yes / No
2. Any other heredity conditions the doctor should be aware of? ***Circle*** Yes / No
   If yes, please list: _____

Activities of Daily Living/Symptoms/Medications

Patient Name: _____ File #: _____

Date: _____

Daily Activities: Effects of Current conditions on Performance:

Please identify how your current condition is affecting your ability to perform and carry out these activities that are a routine in one's daily life:

Please put a check in the box to what best suits you and your situation

Bending	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Concentrating	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Doing Computer Work	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Gardening	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Playing Sports	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Recreation Activities	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Shoveling	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Sleeping	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Watching TV	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Carrying things	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Dancing	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Dressing yourself	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Lifting	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Pushing	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Rolling Over	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Sitting	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Standing	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Working	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Climbing	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Doing Chores	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Driving	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Performing Sexual Activity	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Reading	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Running	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Sitting or Standing	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐
Walking	No Effect ☐	Painful (can do) ☐	Painful (limits) ☐	Unable to Perform ☐

Please indicate with a **P** for *Past*, **C** for *Currently have*, and **N** for *Never had*:

Headache____	Pregnant (Now)	Dizziness____	Prostate Problems____	Ulcers____
Neck Pain____	Frequent Colds/Flu___	Loss of Balance____	Impotence/Sexual Dysf.___	Heartburn____
Jaw Pain, TMJ____	Convulsions/Epilepsy___	Fainting____	Digestive Problems____	Heart Problem___
Shoulder Pain____	Tremors____	Double Vision____	Colon Trouble____	High Blood Press.____
Upper Back Pain___	Chest Pain____	Blurred Vision____	Diarrhea /Constipation___	Low Blood Press.____
Mid Back Pain____	Pain w/ Cough/Sneeze___	Ringing in Ears____	Menopausal Problem___	Asthma____
Low Back Pain____	Foot or Knee Problems___	Hearing Loss____	Menstrual Problem____	Difficulty Breathing___
Hip Pain____	Sinus/Drainage Problem___	Depression____	PMS____	Lung Problems____
Back Curvature___	Swollen/Painful Joints___	Irritable____	Bed Wetting____	Kidney Trouble____
Scoliosis____	Skin Problems____	Mood Changes____	Learning Disability____	Gall Bladder Trouble___
Numbness/Tingling arms, hands, fingers____		ADD/ADHD____	Eating Disorder____	Liver Trouble____
Numbness/Tingling legs, feet, toes____		Allergies____	Trouble Sleeping____	Hepatitis (A,B,C)____

Please list any Prescription & Non-Prescription drugs you take:

_____

_____

Informed Consent:

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, hold certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractor adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at E.P. True Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, methods, and techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-Rays/Imaging Studies

FEMALES ONLY: Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on: ____/____/____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

E.P. True Chiropractic Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled "**HIPPA**" on tables in the reception area. Once you have read this notice, please sign the last page and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

Permitted Disclosures:

1. Treatment purposes – discussion with other health care providers involved in your care
2. Inadvertent disclosures – open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For worker's compensation purposes – to process a claim or aid in investigation
5. Emergency – in the event of a medical emergency we may notify a family member
6. For Public Health and safety – in order to prevent or lesson a serious or eminent threat to the health or safety of a person or general public
7. To Government agencies or law enforcement – to identify or locate suspect, fugitive, material witness or missing person
8. For Military, National Security, Prisoner and Government Benefits purposes
9. Deceased Persons – discussion with coroners and medical examiners in the event of a patient's death
10. Telephone Calls or emails and appointment reminders – **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events
11. Change of ownership – in the event this practice is sold, the new owners would have access to you PHI.

Your Rights:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree with them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-Rays** are original records and you are therefore entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

Complaints:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Kevin Miller at (515)-309-3791. If he is unavailable, you may make an appointment with our receptionist to see him with in 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC, 20201

Patient Initials: _____ - retaining page 1 of 2

_____ Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of _____ Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient's Signature	Date	
_____	_____	
Witness	Date	

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E.P. True Chiropractic

Financial Policies

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay E.P. True Chiropractic its usual charges for all services received through E.P. True Chiropractic, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance to E.P. True Chiropractic, and direct that payment of proceeds be made directly to E.P. True Chiropractic.

RECORDS RELEASE FOR CLAIMS PAYMENT

I authorize that release of medical record information or excerpts thereof to any insurance company or third party payer for utilization of management audit purposes and/or the purposes verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

INSURANCE/PAYMENT

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communication with your insurance carrier on any open claims.

*My signature below represents **I Have Read and Understand** the statement above. I agree to assign insurance benefits to E.P. True Chiropractic whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.*

Patient's Name Signature of Patient or Legal Guardian Date

Our Office Policies

Welcome to E.P. True Chiropractic

As a potential new patient we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or if any of these policies are unclear to you and you would like further explanation before submitting your application of care, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that re achieved and the benefits derives from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us in your life and the lives of those you care about.

 PATIENT PRIVACY ~ Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

 YOUR CARE ~ When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at E.P. True Chiropractic is rendered primary to minimize and reduce subluxations, which are major interferences to the expression of the body's innate wisdom. The doctor uses manual adjustment to accomplish this goal, including but not limiting to Gonstead & Palmer techniques. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structure problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally thereby improving your overall health.

 FIRST THINGS FIRST ~ Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with your care plan recommendations so that you can make the best possible decision regarding your health needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

 PATIENT REPORT OF FINDINGS ~ To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a "Doctor's Report of Findings". The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands thee goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Patient initials: _____ - retaining pages 1 of 2

I hereby acknowledge receiving a copy of this practices "office Policies" a two-page document, the first page which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding the "Notice". I further acknowledge that any concerns regarding these "Policies" as well as all my question have been answered by a qualified member of the staff to my complete satisfaction.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient's Signature	Date	
_____	_____	
Witness	Date	

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